

# Individual authorization for use/disclosure of health information

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**You have a right to receive a copy of this form after you have signed it.**

I have read this form and all of my questions about this form have been answered. By signing below, I acknowledge that I have read and accept all of the above.

Student's Name: \_\_\_\_\_

Signature of Parent/Guardian of Student: \_\_\_\_\_

(REQUIRED IF STUDENT IS UNDER THE AGE OF 18):

Signature Student: \_\_\_\_\_

Date: \_\_\_\_\_

Description of Parent/Guardian's Relationship to Student: \_\_\_\_\_

(E.G., MOTHER, FATHER, GRANDPARENT, OTHER GUARDIAN)